STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TN 37243
www.tennessee.org

TENNESSEE BOARD OF MEDICAL EXAMINERS
(800) 778-4123, ext. 24384 or
(615) 532-3202, ext. 24384

APPLICATION INSTRUCTIONS FOR TENNESSEE DISTINGUISHED FACULTY MEDICAL LICENSURE

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice medicine.

DONE

1. Complete, have notarized, and mail the application pages 1 through 6. _____
2. Complete and mail Attachment 1 to your medical school for transcript of courses, grades, and degree. _____
3. Submit a clear and recognizable, recently taken bust photograph of yourself that shows the full head, face forward from at least the shoulders up. _____
4. Submit proof of your citizenship in the United States or Canada or evidence of being legally entitled to live and work in the United States. (Notarized copies of birth certificates, naturalization papers, H-1 visas, or current passports are acceptable.) _____
5. **Attach to the application and submit a check or money order in the amount of $410.00, payable to the Tennessee Board of Medical Examiners.** _____
6. Have a letter submitted directly from the Dean of an accredited medical college in Tennessee stating that you have a full-time appointment at the rank of professor. _____
7. Have letters of support attesting to your distinguished status sent directly from all of the following on their letterheads:
   (a) The Dean of the appointing/employing medical college. _____
   (b) All department chairperson, at the appointing medical college, who are directly involved with your faculty assignments. _____
   (c) Have a total of five (5) letters of recommendation submitted directly from academic colleagues from outside Tennessee including other nationally or internationally recognized experts in your specialty area and/or from former medical school deans. _____
8. Have certifications submitted of your current and active membership in good standing in at least two (2) medical specialty societies that have restricted and selective membership based on academic and/or practice related criteria. (Medical societies must provide a copy of membership criteria) Certification must be sent directly to the Board office from the society. _____

9. Have certifications sent from at least two (2) medical educational institutions, either abroad or in the United States, which indicate that you have been or were invited to be a lecturer or visiting professor. These should indicate the applicable dates, lecture topics, and/or educational assignments. _____

10. Submit the dates, location, and sponsoring specialty organizations for at least two (2) national or international medical meetings at which you delivered scholarly medical papers along with copies of at least two (2) such delivered papers. The meetings must have been conducted by or for your speciality membership. _____

11. Complete and mail the Profile Questionnaire pages 1 through 6. _____

UNDERSTANDING THE APPLICATION PROCESS

1. All application fees are non-refundable.

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Tennessee Board of Medical Examiners
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243 (37228 for overnight or special courier mail)

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.

4. Periodic updates for applications will be mailed to the address provided by the applicant. Calls for updates are not accepted unless a problem develops.

5. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board office sixty (60) days from the date of the initial deficiency letter. Files not completed within sixty (60) days will be closed.

6. Absent any complicating factors, the average application processing time is eight (8) weeks. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination. If approved, you may begin work upon receipt of the approval letter. Certificates are not released until the Board ratifies the licensure approval.

7. If an address change occurs at any time during the application process, you must notify the Board office, in writing, immediately. All correspondence and certificates are mailed to the address submitted by the applicant.

Thank you for your cooperation. We will make every effort to expedite your application in an efficient manner.

For Office Use Only	
06-001	$400
06-006	$ 10
Total	$410

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APPLICATION FOR DISTINGUISHED FACULTY LICENSURE AS A MEDICAL DOCTOR

READ INSTRUCTIONS PRIOR TO COMPLETING APPLICATION. APPLICANTS MUST COMPLY WITH ALL INSTRUCTIONS.

FILL IN ALL BLANKS; IF NOT APPLICABLE, STATE N/A

Attach to this application a check or money order in the amount of $410, payable to the Tennessee Board of Medical Examiners.

PERSONAL INFORMATION

Name in full: _____
(*First*) (*Middle/Maiden*) (*Last*)

Have you been known by any other name? Yes ____ No ____ If yes, list names: _____

Date of Birth: Mo._____ Day_____ Yr. ____ Place of Birth: _____
(*City*) (*State*)

Social Security Number: _____-_____-_____ U.S. Citizen: Yes _____ No _____
Sex: Female Male _____

Present Mailing Address: _____

Home Phone: (____) _____

Work Phone: (____) _____

EDUCATIONAL AND EXAMINATION INFORMATION

PRE-MEDICAL EDUCATION

From: _____ To: _____ _____ _____
Mo/Yr *Mo/Yr* *Educational Institute* *Location*

From: _____ To: _____ _____ _____
Mo/Yr *Mo/Yr* *Educational Institute* *Location*

From: _____ To: _____ _____ _____
Mo/Yr *Mo/Yr* *Educational Institute* *Location*

MEDICAL EDUCATION

I have spent _____ years in the study of medicine in the medical educational institutions below:

From: _____ To: _____ _____ _____
Mo/Yr *Mo/Yr* *Educational Institute* *Location*

From: _____ To: _____ _____ _____
Mo/Yr *Mo/Yr* *Educational Institute* *Location*

From: _____ To: _____ _____ _____
Mo/Yr *Mo/Yr* *Educational Institute* *Location*

POSTGRADUATE TRAINING

I have spent _____ years in medical training in the medical educational institutions below:

From: _____ To: _____ _____ _____
Mo/Yr *Mo/Yr* *Educational Institute* *Location*

From: _____ To: _____ _____ _____
Mo/Yr *Mo/Yr* *Educational Institute* *Location*

From: _____ To: _____ _____ _____
Mo/Yr *Mo/Yr* *Educational Institute* *Location*

I have taken the following medical licensure examinations: (Check all applicable)

1._____ National Boards (NBME) Certificate Number _____
2._____ FLEX examination administered by the State of _____on _____.
(Date(s))
3._____ Licensure by the Medical Council of Canada (LMCC)
4._____ USMLE
5._____ State Board administered by _____ prior to 1972.
(State)
6._____ None of the above.

Are you Board-Certified? _____ If so, identify specialty: _____

Name and address of educational institution at which you are receiving a professorial appointment:

_____
_____
_____

PUBLICATION AND LICENSURE INFORMATION

List and provide citations to any and all publications in professional journals in which you are the author or coauthor. Additional pages may be attached to this form if necessary.

List below **ALL STATES, COUNTRIES, OR PROVINCES** in which you **HAVE EVER BEEN OR ARE CURRENTLY** licensed as a medical doctor. Additional pages may be added if necessary.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

List below **ALL STATE, COUNTRIES, OR PROVINCES** in which you **HOLD OR HAVE EVER HELD** a license as a health professional other than a Medical Doctor.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative,** attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, and/or agencies must be submitted along with this application.***

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice medicine"** is to be construed to include all of the following:

   a. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned medical judgments, to learn, and keep abreast of medical developments;

   b. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and

   c. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV, tuberculosis, drug addiction, and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g., heroin, or cocaine) as well as the use of controlled substances that are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?	____	____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	____	____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?	____	____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity, and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS:	YES	NO
2. Do you currently use chemical substances?	____	____
If yes, do they in any way impair or limit your ability to practice medicine with reasonable skill and safety?	____	____
3. Are you currently engaged in the illegal use of controlled substances?	____	____
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	____	____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?	____	____
5. If you have ever held or applied for a license or certificate to practice medicine in any state, country, or province, has or was it ever been denied, reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, or voluntarily surrendered under threat of restriction or disciplinary action?	____	____
7. Have you ever failed a medical licensure examination?	____	____
8. Have you ever applied for and been denied a state or federal controlled substance certificate?	____	____
If you have possessed such a certificate has it ever been revoked, suspended, restricted, otherwise disciplined, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____
9. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic offense?	____	____
10. Have you ever been rejected or censured by a medical society?	____	____
11. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you;	____	____
b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	____	____
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	____	____
12. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, or voluntarily surrendered under threat of investigation or disciplinary action?	____	____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, M.D., of _____
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application, attests to the truth of each made in said application. I further swear that I have read and understand the law and the Rules and Regulations that were enclosed in the application packet and agree to abide by them in the practice of medicine in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice medicine.

AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

RELEASE from liability the Board, its staff, and all their representatives and any and all organizations that provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me this _____ day of _____, _____.

_____ Affix Seal Here
NOTARY PUBLIC

My Commission expires _____

ATTACHMENT 1

STATE OF TENNESSEE
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APPLICANT: Supply the information requested in this box and then mail this entire form to your medical school.

Full Name: _____
(Last) (First) (Middle/Maiden)

Address: _____ Social Security Number: ___ - ___ - ___

_____

_____

_____

Student Identification Number: _____

Year of Graduation: _____

Degree Obtained: _____

TO WHOM IT MAY CONCERN:

I am applying for a license to practice medicine in the State of Tennessee.

Please forward an original graduate transcript of courses, grades, and degree bearing the institution's official seal to:

State of Tennessee
Board of Medical Examiners
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243 (37228 for courier service only)

Thank you for your cooperation and prompt response.

_____ _____
Applicant's Signature Date

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